CHAPTER 13
SECTION 6.5

HOSPITAL REIMBURSEMENT - TRICARE/CHAMPUS INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

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I. ISSUE

How is the TRICARE/CHAMPUS inpatient mental health per diem payment system to be used in determining reimbursement for psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the TRICARE/CHAMPUS DRG-based payment system?

II. POLICY

A. TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System.

The TRICARE/CHAMPUS inpatient mental health per diem payment system shall be used to reimburse for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the TRICARE/CHAMPUS DRG-based payment system. The system uses two sets of per diems. One set of per diems applies to psychiatric hospitals and psychiatric units of general acute hospitals that have a relatively high number (25 or more per federal fiscal year) of TRICARE/CHAMPUS mental health discharges. For higher volume hospitals and units, the system uses hospital-specific per diem rates. The other set of per diems applies to psychiatric hospitals and units with a relatively low number (less than 25 per federal fiscal year) of TRICARE/CHAMPUS mental health discharges. For higher volume providers, the contractors are to maintain files which will identify when a provider becomes a high volume provider; the federal fiscal year when the provider had 25 or more TRICARE/CHAMPUS mental health discharges; the calculation of each provider's high volume rate; and the current high volume rate for the provider. For lower volume hospitals and units, the system uses regional per diems, and further provides for adjustments for area wage differences and indirect medical education costs and additional pass-through payments for direct medical education costs.

B. Applicability of the TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System.

1. Facilities. The TRICARE/CHAMPUS inpatient mental health per diem payment system applies to services covered that are provided in Medicare prospective payment system (PPS) exempt psychiatric hospitals and Medicare PPS exempt psychiatric specialty units of other hospitals. In addition, any psychiatric hospital that does not participate in Medicare, or any other hospital that has a psychiatric unit that has not been so designated for

exemption from the Medicare PPS because the hospital does not participate in Medicare, must be designated as a psychiatric hospital or psychiatric specialty unit for purposes of the TRICARE/CHAMPUS inpatient mental health per diem payment system upon demonstrating that it meets the same criteria as found in Chapter 13, Section 6.1D. The contractor is responsible for requesting from a hospital that does not participate in Medicare sufficient information from that hospital which will allow it to make a determination as to whether the hospital meets the criteria found in this section in order to designate it as a TRICARE/CHAMPUS DRG exempt hospital or unit. The TRICARE/CHAMPUS inpatient mental health per diem payment system does not apply to mental health services provided in non-psychiatric hospitals or non-psychiatric units. Substance use disorder rehabilitation facilities would not be reimbursed under the inpatient mental health per diem payment system.

2. DRGs. All hospitals' and units' covered inpatient claims which are classified into a mental health DRG of 425 through 432 or a substance use disorder DRG of 433 through 437 and DRGs 900 and 901 shall be subject to the TRICARE/CHAMPUS inpatient mental health per diem payment system. (See Chapter 13, Section 6.1B for other DRG admissions.) When a patient is admitted to a psychiatric hospital or a psychiatric unit of a general acute medical hospital with the primary diagnosis being mental health, and during the stay the patient needs medical services, the entire stay is covered by the TRICARE/CHAMPUS per diem. The medical services are not reimbursed separately. When the mental health per diems were established, all charges (including non-mental health services) were used as long as the admission grouped to a mental health DRG. The psychiatric hospital or psychiatric unit of a general acute medical hospital must provide or make arrangements for medical services when they are needed for a mental health admission. If medical services are provided by another provider, other than the admitting psychiatric hospital or psychiatric unit of a general acute medical hospital and the patient is not discharged from the psychiatric hospital or unit of a general acute medical hospital, the provider must look to the psychiatric hospital or unit of a general acute medical hospital for reimbursement of the medical services. The only exception is found in paragraph II.I.3. This paragraph states when the primary diagnosis is not mental health (admission groups to a non-mental health DRG) reimbursement is based on billed charges. Concerning the matter of provided or arranged medical services by the non-psychiatric facility, such services will not be separately cost-shared, but will be cost-shared on an inpatient basis under the mental health per diem payment system (see Chapter 13, Section 11.5).

3. State Waivers. The TRICARE/CHAMPUS DRG-based payment system provides for state waivers and has exempted Maryland (Chapter 13, Section 6.1D). The TRICARE/CHAMPUS inpatient mental health per diem payment system does partially apply to Maryland. Prior to October 1, 1994, specialty psychiatric hospitals in this state will be reimbursed under the TRICARE/CHAMPUS inpatient mental health per diem payment system. Psychiatric units in this state will be exempt from the TRICARE/CHAMPUS inpatient mental health per diem payment system and will paid on billed charges. Effective October 1, 1994, the contractor is to establish hospital-specific mental health per diem rates for existing high volume providers based on the provider's allowed billed charges for FY 1994. These per diems will be limited to the TRICARE/CHAMPUS cap amount for high volume providers and will be updated annually by the update factor used to adjust per diem rates of other providers under the TRICARE/CHAMPUS mental health per diem payment system. No deflator will be applied to these newly established rates.

For new high volume providers that attain this status after FY 94, the provider's allowed billed charges for the government fiscal year when they qualify as a high volume provider will be used to establish the high volume rate. Again, the deflator will not be used to adjust the rate and such rates will be subject to the cap amount. The contractor will use the update factors for adjusting the rates for future years.

C. Hospital-Specific Per Diems for Higher Volume Psychiatric Hospitals and Units.

1. Hospital-Specific Per Diem. A hospital-specific per diem amount shall be calculated for each hospital or unit with a higher volume of TRICARE/CHAMPUS mental health discharges. The base period per diem amount shall be equal to the hospital's average daily charge for charges allowed by TRICARE/CHAMPUS in the base period (July 1, 1987 through May 31, 1988). The average daily charge in the base period shall be calculated by reference to all TRICARE/CHAMPUS claims paid (processed) during the base period. The base period amount, however, may not exceed the caps described in the following paragraph II.C.2.

a. The hospital-specific per diem rates were originally calculated based on the procedures and data referred to in the final rule which was published in the Federal Register on September 6, 1988. These rates were effective for inpatient mental health admissions occurring on or after January 1, 1989.

b. Effective October 1, 1989, the hospital-specific rates were recalculated based on more accurate TMA data.

c. As a result of the October 1, 1989, recalculation, it was determined that a few hospitals were underpaid based on the difference between the originally calculated per diems and the recalculated per diems. For these providers, the contractor will retroactively make payment adjustments back to January 1, 1989. A list of these providers were provided by TMA.

d. As published in the Federal Register March 7, 1995, changes to the mental health per diem payment system were made.

(1) Cap amount changed - the base period per diem amount may not exceed the 70th percentile of the average daily charge weighted for all discharges throughout the United States from all higher volume hospitals.

(2) Update factors - all per diems in effect at the end of fiscal year 1995 shall remain in effect, with no additional update, throughout fiscal years 1996 and 1997.

2. Cap Amount. Prior to April 6, 1995, the base period per diem amount may not exceed the eightieth percentile of the average daily charge weighted for all mental health discharges throughout the United States from all higher volume psychiatric hospitals and units. Effective for care on or after April 6, 1995, the cap amount is established at the 70th percentile.

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
$629	1/1/89 through 9/30/89

CAP PER DIEM AMOUNT	FOR SERVICES RENDERED
614	10/1/89 through 9/30/90
641	10/1/90 through 9/30/91
672	10/1/91 through 9/30/92
701	10/1/92 through 9/30/93
732	10/1/93 through 9/30/94
760	10/1/94 through 4/5/95
645	4/6/95 through 9/30/97
645	10/1/97 through 9/30/98
660	10/1/98 through 9/30/99

3. Request for Recalculation of Per Diem Amount. Any psychiatric hospital or unit which has determined TMA calculated a hospital-specific per diem which differs by more than five ($5) dollars from that calculated by the hospital or unit, may apply to the appropriate contractor for a recalculation unless the calculated rate has exceeded the cap amount described in the previous paragraph. The recalculation does not constitute an appeal, as the per diem rates are not appealable. Any hospital which has not already requested and received an administrative review determination on their hospital specific rate will have 60 days from November 28, 1989 (the date of the Federal Register notice) to request an administrative review of the per diem rates that are effective for services provided on or after October 1, 1989. Up to an additional 60 days will be allowed to provide evidence in support of the hospital's position. There is no time limit in which the recalculation must be requested for per diem rates that were effective January 1, 1989. The contractor will have 60 calendar days, including the 21 days for processing adjustments, from the date of the request to complete the requested review. Unless the provider can prove that the contractor calculation is incorrect, the contractor's calculation is final. The burden of proof shall be on the hospital or unit. The contractor shall follow these steps when verifying the hospital's or unit's calculated hospital-specific per diem.

Step 1: Data submitted by the hospital should be adjudicated against the contractor's provider history file for the base period used to calculate the hospital-specific per diem.

Step 2: Days and charges submitted by the hospital must be verified by the contractor as being covered days and allowed charges, without consideration of other health payments for mental health discharges during the base period.

Step 3: The contractor should determine that the primary diagnosis associated with the discharges during the base period were only for mental health (DRG 425 through 432) or substance use disorder (DRG 433 through 437 and DRGs 900 and 901).

Step 4: If after completing the above steps, the contractor finds that the data submitted by the hospital is correct or is partially correct, the

contractor would then adjust the per diem. This means the contractor would recalculate the per diem by accumulating all allowed mental health and substance use disorder charges that were paid (processed) during the base period and dividing these charges by covered days associated with the paid (processed) charges for the base period.

EXAMPLE: The contractor is to compute a per diem based on averaged allowed charges of paid (processed) claims for the base period (7/1/87-5/31/88). This means the contractor will average all allowed charges paid (processed) by TRICARE/CHAMPUS and other health insurance (OHI) during the base period.

DISCHARGE	LOS	BILLED	ALLOWED	PAID/OHI	PAID/ TRICARE/ CHAMPUS	DATE OF PAYMENT
1. 4/1/87	10	$5000	$4000	$1000	$3000	7/1/87@
2. 5/15/87	15	9000	8000	2000	6000	6/25/87*
3. 7/1/87	12	8400	8000	8400	8000	8/25/87
4. 8/15/87	5	2500	2500	2500	-0-	10/1/87
5. 3/15/88	10	4000	3500	1000	2500	5/31/88
6. 4/15/88	20	14000	12000	2000	10000	6/1/88*
TOTAL	37	19900	18000	4500	13500	

Total allowed charges paid during the base period equals	$18000
Total days associated with these allowed charges equals	37
Average per diem for the base period equals ($18000 divided by 37)	$486.49
Average per diem updated by the update factor of 1.1% (Update factor brings base period per diem up to 10/1/88)	$491.84
Per diem effective 1/1/89 rounded up to the next whole dollar	$492

NOTE: The allowed column includes the patient's cost-share and deductible amounts.

@ Date of payment (processed), not date of discharge is the controlling factor for including or excluding allowed charges in the per diem computation.

*Allowed charges not paid (processed) during the base period were not included

in the calculation.

Step 5: For per diem rates that are effective for services provided on or after October 1, 1989, an additional 5.5 percent is to be added to the base period per diem rate. In the above example, the $491.84 would be increased to $518.89 and rounded to the next whole dollar $519. ($491.84 x 1.055 = $518.89)

Step 6: If the recalculation results in a higher per diem, the contractor would then notify the hospital of the revised rate and make it retroactive to the effective date of the originally established hospital-specific per diem. (A lump-sum retroactive payment may be required if payments were made at a lower original hospital-specific per diem amount. This payment will be the result of an adjustment based upon each claim processed during the retroactive period for which an adjustment is needed, and will be subject to the 21 day time frame for processing adjustments.) If the recalculation results in a per diem lower than the original per diem, the contractor would notify the hospital that the revised rate will be applied prospectively, effective as of the date of notification to the hospital. No retroactive adjustment shall be required in this case. However, in fraud and abuse cases, the rate would be made retroactive and recoupment would be required. The contractor must maintain the revised rate, the date of the revision, and the effective date of the new contractor's rate if different from the date of the revision. For suppression of the EOB form being sent to the beneficiary, see OPM Part Two, Chapter 4, Section II.C.

Step 7: After completing steps 1 through 3 above, the contractor determines that an adjustment to the hospital's or unit's original hospital-specific per diem is not necessary, the contractor should notify the hospital of the determination and why adjustment will not be made.

D. Regional Per Diems for Lower Volume Psychiatric Hospitals and Units.

1. Regional Per Diem. Hospitals and units with a lower volume of TRICARE/CHAMPUS patients shall be paid on the basis of a regional per diem amount, adjusted for area wages and indirect medical education. Base period regional per diems shall be calculated based upon all TRICARE/CHAMPUS lower volume hospitals' and units' claims paid (processed) during the base period. Each regional per diem amount shall be the quotient of all covered charges (without consideration of other health insurance payments) divided by all covered days of care, reported on all TRICARE/CHAMPUS claims from lower volume hospitals and units in the region paid (processed) during the base period, after having been standardized for indirect medical education costs, and area wage indexes. Direct medical education costs shall be subtracted from the calculation. The regions shall be the same as the federal census regions.

REGION	STATES
Northeast:	
New England	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut
Mid-Atlantic	New York, New Jersey, Pennsylvania
Midwest:	
East North Central	Ohio, Indiana, Illinois, Michigan, Wisconsin
West North Central	Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas
South:	
South Atlantic	Delaware, Maryland, D.C., Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida
East South Central	Kentucky, Tennessee, Alabama, Mississippi
West South Central	Arkansas, Louisiana, Texas, Oklahoma
West:	
Mountain	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada
Pacific	Washington, Oregon, California, Alaska, Hawaii

2. Request for Recalculation of Per Diem Amount. Any hospital or unit that has determined the regional per diem amount applicable to that hospital or unit has been incorrectly calculated by TMA by more than five ($5) dollars may submit to the appropriate contractor evidence supporting a different regional per diem. The burden of proof shall be on the hospital or unit. Since regional per diem rates overlap contractor regional boundaries, a contractor which receives notification that a regional per diem is being challenged may need to obtain charge and other statistical information from other contractors in order to make a determination as to the validity of the challenge before an adjustment to the per diem can be justified. If a contractor receives notification that a regional per diem is being challenged, it should immediately inform TMA (DO). Upon receiving this information, TMA Operations Directorate (DO) will provide additional instructions to the contractor.

3. Adjustments to Regional Per Diem Rates. Two adjustments shall be made to the regional per diem rates when applicable.

a. Area Wage Adjustment. The same area wage indexes used for the TRICARE/CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1G) shall be applied to the wage portion (wage portion percentage split will be the same used for DRGs which is currently 71.40 percent) of the applicable regional per diem rate for each day of the admission. In Fiscal Years 1989 and 1990, the percentages were 74.39 and 73.84 percent respectively. Since Fiscal Year 1990, the percentage has been 71.40 percent. For Fiscal Years 1998 and 1999, the percentage is 71.1 percent.

b. Indirect Medical Education Adjustment. The indirect medical education adjustment factors shall be calculated for teaching hospitals in the same manner as in the TRICARE/CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1G) and applied to the applicable regional per diem rate for each day of the admission. For an exempt psychiatric unit in a teaching hospital, there should be a separate indirect medical education adjustment factor for the unit (separate from the rest of the hospital) when medical education applies to the unit.

c. The adjusted regional per diem rate is not to be rounded up to the next whole dollar.

4. Reimbursement of Direct Medical Education Costs. In addition to payments made to lower volume hospitals and units, TRICARE/CHAMPUS shall annually reimburse hospitals for actual direct medical education costs associated with TRICARE/CHAMPUS beneficiaries. The first payment may cover a period of less than a full year--from the effective date of the TRICARE/CHAMPUS per diem payment system to the end of the hospital's fiscal year end. This reimbursement shall be done pursuant to the same procedures as are applicable to the TRICARE/CHAMPUS DRG-based payment system (see Chapter 13, Section 6.1H).

NOTE: No additional payment is to be made for capital costs. Such costs have been covered in the regional per diem rates which are based on charges.

E. Base Period and Update Factors.

1. Hospital-Specific Per Diem Calculated Using Date of Payment. The base period for calculating the hospital-specific and regional per diems, as described above is federal fiscal year 1988. The base period calculations shall be based on actual claims paid (processed) during the period July 1, 1987 through May 31, 1988, trended forward to September 30, 1988, using a factor of 1.1 percent.

2. Hospital-Specific Per Diem Calculated Using Date of Discharge. Upon application by a higher volume hospital or unit to the appropriate contractor, the hospital or unit may have its hospital-specific base period calculations based on TRICARE/CHAMPUS claims with a date of discharge (rather than date of payment) between July 1, 1987 through May 31, 1988, if it has generally experienced unusual delays in TRICARE/CHAMPUS claims payments and if the use of such an alternative data base would result in a difference in the per diem amount of at least $5.00 with the revised per diem not exceeding the cap amount. For this purpose, the unusual delays mean that the hospital's or unit's average time period between date of discharge and date of payment is more than two standard deviations (204 days) longer than the national average (94 days). The burden of proof shall be on the hospital.

3. Updating Hospital-Specific and Regional Per Diems. The hospital-specific per diems and the regional per diems calculated for the base period shall be in effect for admissions on or after January 1, 1989; there will be no additional update for fiscal year 1989. For subsequent fiscal years, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system. In accordance with the final rule published March 7, 1995, in the Federal Register, all per diems in effect at the end of fiscal year 1995 shall remain frozen through fiscal year 1997. Hospitals and units with hospital-specific rates will be notified of their respective rates prior to the beginning of each federal fiscal year by the contractors. New hospitals shall be notified by the contractor at such time as the hospital rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the Federal Register prior to the start of that fiscal year and will be furnished to contractors by TMA.

UPDATE FACTOR	FISCAL YEAR	DATE PUBLISHED
5.5 percent	1990	11/28/89
4.2545 percent	1991	12/14/90
4.7 percent	1992	10/30/91
4.2 percent	1993	12/16/92
4.3 percent	1994	9/30/93
3.7 percent	1995	10/3/94
-0- percent	1996	Frozen
-0- percent	1997	Frozen
-0- percent	1998	10/6/97
2.4 percent	1999	9/28/98

4. Claims priced by day of service. All claims reimbursed under the TRICARE/CHAMPUS mental health per diem payment system are to be priced for each day of service (using the rate in effect on the day of service) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the day of service. In order to do this, contractors shall maintain at least three (3) iterations of per diem rates, including indirect medical education adjustment factors, wage indexes, etc., in the contractor's on-line system. If the claim filing deadline has been waived and the day of service is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest per diem rate on the contractor's system.

F. Higher Volume Hospitals and Units.

1. Higher Volume of TRICARE/CHAMPUS Mental Health Discharges During the Base Period. Any hospital or unit that had an annual rate of 25 or more TRICARE/CHAMPUS mental health discharges during the period July 1, 1987 through May 31, 1988, shall be considered a higher volume hospital or unit during federal fiscal year 1989 and all subsequent fiscal years. The intent of this provision is to "annualize" the discharge rate during the eleven (11) month base period, to a full twelve (12) months. As a result, any

hospital or unit establishing a record of 23 or more actual TRICARE/CHAMPUS mental health discharges during the base period, would qualify as a high volume provider.

EXAMPLE: 23 actual TRICARE/CHAMPUS mental health (MH) discharges July 1, 1987-May 31, 1988.

$\frac{23 \text{ MH Discharges}}{11 \text{ months}} = 2.09$ MH discharges/month

2.09 x 12 months = 25.08 MH discharges/year.

All other hospitals and units covered by the TRICARE/CHAMPUS inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

2. Higher Volume of TRICARE/CHAMPUS Mental Health Discharges in Subsequent Fiscal Years and Hospital-Specific Per Diem Calculation. In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE/CHAMPUS mental health discharges, that hospital or unit shall be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years. If TRICARE/CHAMPUS discharges group into DRG 424 or any other non-mental health DRG, these discharges will not count toward meeting the 25 or more TRICARE/CHAMPUS mental health discharges. TRICARE/CHAMPUS mental health discharges that are not covered under standard TRICARE/CHAMPUS will not count toward meeting the 25 or more TRICARE/CHAMPUS mental health discharges. In addition, TRICARE/CHAMPUS mental health discharges for benefits covered under a demonstration program would not be counted toward meeting the 25 or more TRICARE/CHAMPUS mental health discharges. Managed Care Support Contract for CA/HI in-system mental health discharges are not to be included in the counting of mental health discharges. However, services provided to a Managed Care Support Contract for CA/HI beneficiary outside the Managed Care Support Contract for CA/HI contracted area is considered to be Standard TRICARE/CHAMPUS business. This means that any such beneficiary discharged from a psychiatric hospital or unit outside the Managed Care Support Contract for CA/HI contracted area would be included in the determination for high volume status for that hospital. If a TRICARE/CHAMPUS discharge is paid in part or in full by other insurance, yet the admission would have been covered by TRICARE/CHAMPUS had there not been other health insurance, this discharge would be counted toward meeting the 25 or more TRICARE/CHAMPUS mental health discharges.

NOTE: Only standard TRICARE/CHAMPUS mental health discharges reimbursed under the mental health per diem payment system for mental health and substance use disorder services provided by DRG-exempt psychiatric hospitals and DRG-exempt psychiatric units are to be included in the determination of high or low volume provider status.

The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE/CHAMPUS mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE/CHAMPUS mental health discharges and the base period. The base period amount, however, can not exceed the cap described above. Once a statistically valid rate is established based on a year in which the hospital or unit had

at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem. When a hospital-specific per diem is retroactively implemented and the calculated hospital-specific per diem results in a lower rate than the regional rate which had been paid during the interim period, recoupment of the difference would not be made.

To illustrate, suppose a hospital or unit has 15 TRICARE/CHAMPUS admissions in the base period, 20 in FY-1989 and 25 in FY-1990. Payments during FY-1989 and FY-1990 would have been based on the applicable regional rates. The hospital-specific per diem for that hospital, which will begin to apply in FY-1991, will be calculated by taking the hospital's or unit's average daily charge in FY-1990, adjusting it back to the base period by the percent of change in average daily charges for all high volume hospitals and units from the base period to FY-1990, applying the cap (if applicable), and updating the base period per diem to FY-1991 by the same update factors as apply to other higher volume hospitals and units.

a. The TRICARE contractor shall be requested at least annually to submit to the TMA Office of Medical Benefits and Reimbursement Systems within 30 days of the request a listing of high volume providers that qualified as high volume during the most recent government fiscal year. Periodically, additional information may be requested by TMA concerning high volume providers. This requested information will be used in the calculation of the percent of change and the deflator factor.

b. Percent of change and deflator factor (DF).

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1989	14.98%	1.1498
September 30, 1990	31.69%	1.3169
September 30, 1991	63.18%	1.6318
September 30, 1992	85.81%	1.8581
September 30, 1993	94.48%	1.9448
September 30, 1994	106.94%	2.0694
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383
September 30, 1997	126.20%	2.2620

EXAMPLE: A hospital that did not have the required number of TRICARE/CHAMPUS mental health discharges during the base period, but does have 25 or more TRICARE/CHAMPUS mental health discharges for the 12 month period ended September 30, 1993, would be eligible for a hospital-specific per diem rate. If this is not a new provider, the hospital-specific per diem rate would be effective for services provided on or after October 1, 1993. The calculated numbers that follow are based on actual TRICARE/

CHAMPUS charge data and have been used to establish the percent of change.

-The average daily charge for base period (July 1, 1987, through May 31, 1988, trended forward to September 30, 1988, using an update factor of 1.1 percent for all higher volume hospitals & units) is $484.81.

-The average daily charge for 12 month ended September 30, 1993 (All higher volume hospitals & units) is $942.88.

-The change in average daily charges is reflected in an increase in average daily charges ($942.88-$484.81) is $458.07.

-The percent of change ($458.07 divided by $484.81) is 94.48%.

The contractor shall follow the subsequent steps in establishing the hospital-specific rate.

Step 1: To reflect the percent of change and show the above hospital-specific per diem at the base year value, the per diem rate is divided by 1.9448, the deflator factor. $411.35 ($800 divided by 1.9448 = $411.35)

Step 2: Hospital-specific per diem rate for a hospital that had 25 or more TRICARE/CHAMPUS mental health discharges during the 1993 federal fiscal year. (Allowed billed charges processed during the period, October 1, 1992, through September 30, 1993, divided by allowed days associated with these charges.) $800

Step 3: $411.35 would be rounded and would be the hospital's specific per diem rate at January 1, 1989. $412

Step 4: $412 would be updated by the update factors for fiscal years 1990, 1991, 1992, 1993, and 1994 of 5.5 percent, 4.2545 percent, 4.7 percent, 4.2 percent, and 4.3 percent respectively. The hospital-specific per diem rate for the hospital in this example would be ($412 x 1.055 = $434.66, $435 x 1.042545 = $453.51, $454 x 1.047 = $475.34, $476 x 1.042 = $495.99, $496 x 1.043 = $517.33) rounded to $518, effective October 1, 1993. The contractor should note that all per diems are to be rounded to the next whole dollar, i.e., $520.01 would be rounded to $521.

NOTE: The contractor should consult provider history to determine that a provider has not had the necessary number of TRICARE/CHAMPUS mental health discharges in the base period or in a previous federal fiscal year for high volume status. This will ensure that the provider is classified as a high volume in the proper period of time and will prevent a provider from obtaining high volume status in a period of time when it has been able to raise its charges for a higher hospital-specific per diem rate.

3. New Hospitals and Units. The TRICARE/CHAMPUS inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under TEFRA rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling applicable to new hospitals which are PPS-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE/CHAMPUS mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE/CHAMPUS patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the 21 day time frame for processing adjustments.

By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE/CHAMPUS programs under the present and previous ownership for less than 3 full years. A change in ownership in itself does not constitute a new hospital.

NOTE: A psychiatric hospital or unit that is currently classified as a high volume provider will remain high volume when there is a change of ownership. A change of ownership would not be sufficient reason to honor a request by a hospital or hospital unit to have its high volume hospital-specific rate recalculated. A psychiatric hospital and unit that is currently a low volume provider which has a change in ownership will remain low volume until it can show that it has the required number of TRICARE/CHAMPUS mental health discharges during a federal fiscal year.

A newly-established mental health unit which is a distinct part of an acute medical hospital that is excluded from the prospective payment system does not qualify for the exemption afforded to a new hospital unless the distinct unit is located in a new hospital. New hospitals must provide the contractor with proof that they meet these requirements. This may be a written statement by the hospital official to the contractor supporting this fact. Using this definition, the earliest date a hospital would be considered a new provider under this payment system would be October 1, 1986.

To illustrate how the contractor is to use this data, the following illustration is provided.

Hospital opens October 1, 1986, earliest date for a new hospital under the per diem payment system. If a hospital opened on September 30, 1986, it would not be considered a new hospital.

This hospital does not have the required number of TRICARE/CHAMPUS mental health discharges during the base period. (23 or more mental health discharges during the period July 1, 1987, through May 31, 1988). The contractor should verify this.

This hospital notifies the contractor that during the period October 1, 1988, through September 30, 1989, it had 25 or more TRICARE/CHAMPUS mental health

discharges. It also provides the contractor with the appropriate data which will aid the contractor in making a determination whether this hospital should be classified as high volume. The contractor will search its provider history for this time period and will either confirm or deny this provider as a high volume provider. If the provider is found to have 25 or more TRICARE/CHAMPUS mental health discharges for this period of time, the contractor will compute a hospital-specific per diem rate retroactive back to January 1, 1989. The per diem rate will be computed as follows:

Hospital-specific per diem rate for this hospital. (Allowed billed charges processed during the period, October 1, 1988, through September 30, 1989, divided by allowed days associated with these charges.)	$500
To reflect the percent of change and show the above hospital-specific per diem at the base year value, the per diem rate is divided by 1.1498. ($500 divided by 1.1498 = $434.86)	$434.86
$434.86 would be rounded and would be the hospital's specific per diem rate effective retroactive to January 1, 1989.	$435
To update the per diem, the base year value is updated by the update factors previously discussed in this section.	

Such new hospitals must agree not to bill TRICARE/CHAMPUS beneficiaries for any additional cost-share beyond that determined initially based on the regional rate. For suppression of the EOB from being sent to the beneficiary, see OPM Part Two, Chapter 1, Section VI.G.

NOTE: If the hospital-specific per diem calculated for a new psychiatric hospital or unit is less than the regional per diem rate which the new psychiatric hospital or unit has been paid since becoming a TRICARE/CHAMPUS authorized provider, no recoupment action is to be initiated.

4. Request for a Review of Higher or Lower Volume Classification. Any hospital or unit which TMA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof. The contractor should take the following steps to determine why a hospital or unit may not have qualified as a higher or lower volume hospital or unit.

Step 1: Is the hospital or unit a Medicare-participating provider? If not, has this hospital or unit signed an agreement to participate on all TRICARE/CHAMPUS inpatient claims and meets TRICARE/CHAMPUS standards as an authorized provider of mental health services? (A hospital or unit must be a Medicare-participating provider or have signed a TRICARE/CHAMPUS agreement to participate on all TRICARE/CHAMPUS inpatient claims and meet the TRICARE/CHAMPUS standards as an authorized provider of mental health services.)

Step 2: Is the hospital or unit a Medicare-exempt psychiatric specialty hospital or unit? If not, does the hospital or unit meet the criteria in Chapter 13, Section 6.1D? (If the answer to all of the above questions is "no", then the contractor is not required to proceed any further. A letter explaining why the hospital did not qualify should be sent to the hospital.)

Step 3: If the answer to either of the questions in each of the above steps is yes, then the discharge data for the base period must be reviewed. The hospital must submit to the contractor data which identifies the mental health discharges during the base period. This data should include the patient's name, the sponsor's social security number, the patient's date of birth, the date of admission, the date of discharge, the length of stay, the allowed charges, and corresponding dates of payment or note that payment has not been received.

Step 4: The hospital's submitted data must be verified against the contractor's provider history data file and the UB-92 charge file. If the contractor finds that a discharge reported by the hospital is not appropriate, the reasons should be documented as to why it was not appropriate. However, if at least 25 mental health discharges reported by the hospital are found to be appropriate for the base period the contractor should calculate a hospital-specific per diem for the hospital or unit, and notify the hospital or unit of its hospital-specific per diem (see paragraph II.C. and paragraph II.F.1.). This per diem should become effective retroactive to January 1, 1989. The contractor shall maintain the name of the hospital, its location, the provider's billing number and the date it was determined to be a high volume provider. For a hospital that was classified by TMA as a high volume provider, but can not be supported and verified as such for the base period by the contractor, it should be classified as a low volume provider retroactive to January 1, 1989. For a provider that was improperly classified, the contractor will make additional payments for underpayments, but will not recoup overpayments.

G. Payment for Hospital Based Professional Services

1. Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

2. Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed TRICARE/CHAMPUS separately for hospital based professional services or included those services in the hospital's or unit's charges to TRICARE/CHAMPUS, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services. The contractor has 90 days from the first of the month following the month after the request is received by the contractor to make the change prospective.

The hospital or unit requesting a change in the billing of hospital-based professional services must submit verifiable data including the ratio of average hospital-based professional billed charges to average total billed charges for the fiscal year in which the request to change its billing procedures. This ratio will be used to adjust the hospital's or unit's hospital specific rate. To illustrate how the contractor would make this adjustment the following examples are provided.

EXAMPLE 1: For a hospital or unit that currently has hospital-based professional services included in its hospital-specific per diem rate and wants to bill separately for these services.

(1) Hospital-specific per diem rate. $500

(2) Average hospital-based professional per diem charges. $100

(3) Adjusted hospital-specific per diem rate. $400 ($500 - $100 = $400)

EXAMPLE 2: For a hospital or unit that currently does not have hospital-based professional services included in its hospital-specific per diem rate and wants to include these services in its hospital-specific per diem rate.

(1) Hospital-specific per diem rate. $400

(2) Average hospital-based professional per diem charges. $100

(3) Adjusted hospital-specific per diem rate. $500

EXAMPLE 3: For those hospitals and units that are limited to the cap who request a change in the billing of hospital-based professional services, the hospital-specific rate (the cap amount) would be adjusted as follows:

(1) Hospital-specific per diem rate. $701

(2) Total average charges including hospital-based professional services. $1025

(3) Average hospital-based professional per diem charges. $320

(4) Adjusted hospital-specific per diem rate. $701 ($1025-$320=$705 limited to cap of $701)

(5) Hospital could now bill for the hospital-based professional services separately although the hospital-specific per diem rate would remain at $701.

EXAMPLE 4: Same as example 3 except the amounts are changed.

(1) Hospital-specific per diem rate. $701

(2) Total average charges including hospital-based professional services. $750

(3) Average hospital-based professional per diem charges. $150

(4) Adjusted hospital-specific per diem rate. $600 ($750-$150=$600)

5. Basis and Approval of Request to Change Billing of Hospital-Based Professional Services. A request to change the way hospital-based professional services were traditionally billed in the base period should be the result of an operating change by the hospital such as going from a closed staff to an open staff. After receiving the request from the hospital, the contractor will send the request and the contractor's calculations to TMA (Program Development Branch) for approval of the adjusted per diem. TMA Operations Directorate will inform the contractor of the approved adjusted per diem rate and its effective date.

6. Professional Services not Included in Hospital-Specific Per Diem. Each hospital's-specific rate shall reflect the total Form UB-92 charges submitted and paid (processed) during the base period for all inpatient mental health and substance use disorder services which group into DRGs 425 through 432, DRGs 433 through 437, and DRGs 900 and 901. Claims for inpatient professional mental health service charges routinely submitted separately by the hospital were not included in the per diem calculation, and this practice can continue.

7. Concurrent Care inpatient psychotherapy Limits and Review Requirements. High volume hospitals and units that bill for professional mental health services shall not be subject to the concurrent care inpatient psychotherapy limit of five (5) sessions per week nor review requirements.

Professional mental health services billed by professionals outside the hospital shall be subject to the limit and all review requirements.

8. Non-Mental Health Professional Services and Services Billed by Individual Professional Providers. Under both the hospital-specific and the regional rate reimbursement systems, hospitals may bill separately for non-mental health related professional services. Also, individual professional providers not employed or under contract to the hospital may continue to bill for their professional services provided to hospital inpatients.

H. Leave Days

1. No Payment. TRICARE/CHAMPUS shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

2. Does not Constitute a Discharge/Do not Count Toward Day Limit. TRICARE/CHAMPUS shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital pursuant to this section. Leave days shall not count toward the TRICARE/CHAMPUS day limit pursuant to Chapter 1, Section 12.1B.

l. Exemptions from the TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System.

1. Providers Subject to the TRICARE/CHAMPUS DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier in this section, or which otherwise qualify under that discussion, are exempt from the TRICARE/CHAMPUS inpatient mental health per diem payment system. Such providers should refer to Chapter 13, Section 6.1D for provisions pertinent to the TRICARE/CHAMPUS DRG-based payment system.

2. Services Which Group into DRG 424. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3. Non-Mental Health Procedures. Admissions for non-mental health procedures that group into DRGs 1 through 423, DRGs 438 through 494, and DRGs 600 through 636 in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges. Since it is very unusual for a psychiatric hospital/unit to have an admission for a non-mental health procedure, Contractors should ensure that the claim is correct as submitted--especially the procedures and the provider number--before paying the claim.

4. Sole Community Hospital. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt.

NOTE: Sole community hospitals are recognized only under the Inpatient Mental Health Per Diem Payment System and the DRG-Based Payment System. They are not recognized under any other payment mechanisms.

5. Hospital Outside the Fifty (50) States, D.C. or Puerto Rico. A hospital is exempt if it is not located in one of the 50 states, the District of Columbia, or Puerto Rico.

NOTE: Currently, Puerto Rico is exempt from the per diem payment system. Puerto Rico is not included in any of the current regions for making payment for lower volume providers. There are no high volume providers in Puerto Rico. Due to the small number of mental health claims from psychiatric hospitals and units in Puerto Rico, TMA has decided to pay as billed mental health claims from psychiatric hospitals and psychiatric units in Puerto Rico. Until further notice, claims from these hospitals will be paid as billed for admissions on or after January 1, 1989.

6. Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized TRICARE/CHAMPUS provider. However, any hospital which is subject to the TRICARE/CHAMPUS DRG-based payment system in Chapter 13, Section 6.1D or the TRICARE/CHAMPUS inpatient mental health per diem payment system and which otherwise meets TRICARE/CHAMPUS requirements but which is not a Medicare-participating provider (having completed a HCFA-1561, Health Insurance Benefit Agreement, and a HCFA-1514, Hospital Request for Certification in the Medicare/Medicaid Program) must complete a participation agreement with the contractor. By completing the participation agreement, the hospital agrees to accept

the TRICARE/CHAMPUS-determined allowable amount as payment in full for its services. The participation agreements will be completed only upon request of the hospital to the contractor. A copy of the participation agreement is in Chapter 13, Addendum 1. Any hospital which does not participate in Medicare and does not complete a participation agreement with the contractor will not be authorized to provide services to TRICARE/CHAMPUS beneficiaries. TRICARE/CHAMPUS beneficiaries admitted prior to the effective date of the TRICARE inpatient mental health per diem payment system will be paid through the episode of care based on billed charges if the hospital chooses not to participate. However, services of new admissions by such nonparticipating hospitals and units will not be reimbursed by TRICARE/CHAMPUS.

7. TRICARE/CHAMPUS Demonstration Programs. For those states where a TRICARE/CHAMPUS demonstration program has been implemented, the TRICARE/CHAMPUS inpatient mental health per diem payment system will not apply unless services are provided under the standard TRICARE/CHAMPUS program or services are provided outside the geographic region of the demonstration.

8. TRICARE/CHAMPUS limits. Unless otherwise noted, all limitations such as the day limit pursuant to Chapter 1, Section 12.1B still apply under the TRICARE/CHAMPUS inpatient mental health per diem payment system.

9. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the TRICARE/CHAMPUS DRG-based payment system or the TRICARE/CHAMPUS inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates as found in Chapter 13, Section 6.2.

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